Erie County Department of Health

Confidential Sexually Transmitted Disease Case Report

Fax Completed Forms to: 716-858-7964 or Call Our Secure Reporting Line: 716-858-7697

Patient Information

Last Name:	First Name:	Middle Initial:	
Address:	Zipcode:	Date of Birth (mm/dd/yy):	Age:
City/Town:		Telephone Number (with area code):	

Race:	Ethnicity:	Sex:	Pregnant:
o White o American Indian/Alaskan	o Hispanic	o Male	o Yes
o Black o Asian: _____	o Non-Hispanic	o Female	o No
o Other o Native Hawaiian/Pacific Islander	o Unknown	o Unknown	o Unknown
o Unknown			

Reason for Exam: o Symptomatic o STD Contact o Routine screening o Other: _____

Was Patient Hospitalized for this Illness: o Yes o No o Unknown

Hospital Name: _____
Date Admitted: _____
Date Discharged: _____

Laboratory Data

Date of Test (mm/dd/yy):

Lab Confirmed (√ all that apply):
o Chlamydia o Syphilis
o Gonorrhea

Specimen Source (√ all that apply):
o Urine o Cervix
o Urethra o Vaginal
o Other: _____ o Oral
o Rectal
o Blood

Laboratory Test Type:
o NAAT o RPR
o DNA Probe o TPPA
o Culture o FTA-Abs
o Other: _____ o EIA

Chlamydia

Diagnosis (√ all that apply):
o Asymptomatic
o Symptomatic--Uncomplicated
o Pelvic Inflammatory Disease (cervical or adnexal tenderness)
o Other: _____

Treatment (√ all prescribed):
o Azithromycin, 1 g PO single dose
o Doxycycline, 100 mg PO BID for 7 days
o Erythromycin base, 500 mg PO QID for 7 days
o Erythromycin ethylsucinate, 800 mg PO QID for 7 days
o Levofloxacin, 500 mg PO for 7 days
o Ofloxacin, 300 mg PO BID for 7 days
o Other treatment: _____

Date Rx: _____

Gonorrhea

Diagnosis (√ all that apply):
o Asymptomatic
o Symptomatic--Uncomplicated
o Pelvic Inflammatory Disease (cervical or adnexal tenderness)
o Disseminated
o Other: _____

Treatment (√ all prescribed):
o Ceftriaxone, 250 mg IM single dose
o Cefixime, 400 mg PO single dose
o Single-dose injectible cephalosporin regimen specify: _____
o Other treatment: _____

PLUS one of the following:
o Azithromycin, 1 g PO single dose
o Doxycycline, 100 mg PO BID for 7 days

Date Rx: _____

Syphilis

Stage:
o Primary (chancre, etc)
o Secondary (rash, etc)
o Early latent (<1 yr)
o Late latent (>1 yr)
o Congenital
o Tertiary

Neurosyphilis diagnosed:
o Yes o No

Treatment Given or Referred to:
_____
_____
_____
_____
_____

Date Rx: _____

Reporting Clinic Information

Date:	Diagnosing Clinician:
Facility Name:	Person Completing Form:
Address:	Telephone:
City, State, Zipcode:	Fax #:

Thank you for reporting. Your cooperation is essential for the success of STD prevention and control programs.

Rev. 2/2011